Patient Name (please print): _____ DOB: _____

PATIENT FINANCIAL POLICY

For all services rendered to our patients, we expect the adult accompanying the patient (or the patient if they are not a minor) to make payment. Unless other arrangements with the business office have been made in advance, all co-payments and amounts applied to deductible are due at the time of service. For your convenience we will accept VISA, Master Card, Discover, personal checks, debit cards and cash.

Your insurance policy is a contract between you and your insurance company or employer. As a courtesy, we will file your insurance claim for you if we participate in your plan and if you assign the benefits to our doctor. ***If your insurance company does not pay our office within 45 days we will expect payment from you.***

PRIVACY POLICY

Ashland Children's Clinic considers protection of patient's privacy a very serious matter. Ashland Children's Clinic is compliant with federal and state privacy laws. Your child's personal/protected health information (PHI) will be used by this office only for their treatment and for purposes of payment and practice operations. Any other release of PHI will be made in a manner compliant with current federal and state law.

By signing below you authorize the use of your signature on all paper or electronic insurance submissions, the release of any medical information necessary to process insurance claims and request payments of medical benefits to the physician or supplier of services and permission for the physicians or service provider to request or supply medical records on your behalf.

IDENTITY THEFT PREVENTION

Effective May 1, 2009 the Federal Trade Commission requires all financial institutions and creditors to develop a written identity theft prevention program. Ashland Children's Clinic has implemented Red Flag Rules in order to protect your identity. ***A photo ID will be required for identification purposes.***

AUTHORIZATION FOR MEDICAL TREATMENT OF A MINOR

If your child needs medical services, you as the parent or legal guardian must give permission.

To give treatment to your child in your absence, we must have written permission on file. By signing and dating below, you are giving this permission to the physicians and staff of Ashland Children's Clinic to provide diagnostic and therapeutic medical services (including immunizations, other injections or medical procedures) deemed necessary by the treating health care provider.

I/We do hereby state that I am (we are) the parent(s) or legal guardian of the above named child and give permission for the following person or persons to bring the child to Ashland Children's Clinic for medical treatment: ***(A photo ID will be required from each of these individuals upon first visit)***

Name(s): _____

Name(s): _____

THIS SIGNATURE SHOWS ACCEPTANCE OF THE FINANCIAL, PRIVACY IDENTITY THEFT PREVENTION AND AUTHORIZATION POLICIES.

_____

Signature of Patient or Responsible Party if a Minor Date

_____

Signature of Co-Responsible Party Date